

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

0018879

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 137 Primary Registration District No. 4219 Registrar's No. 144 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0421
2 0421
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Henry</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Henry</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Windsor</u> | | Length of stay in 1b <u>41 years</u> | c. CITY OR TOWN <u>Windsor</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Windsor Hospital</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>610 East Florence</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>James</u> Last <u>MILLER</u> | | | 4. DATE OF Month <u>May</u> Day <u>18</u> Year <u>1964</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mar. 13 1881</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | 9. AGE (last birthday) <u>84</u> IF UNDER 1 YEAR Months Days Hours Min. |
| 11. BIRTHPLACE (City and state or country) <u>Philadelphia, Ill.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U S</u> | |
| 13a. FATHER'S NAME <u>William J. Miller</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary Cox</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Georgie Miller</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>494-16-4965</u> | | 17. INFORMANT Address <u>Clyde Miller Sedalia, Mo.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>Essential Hypertension</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>years</u> <u>years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from <u>3/19/60</u> to <u>5/18/64</u> and last saw him alive on <u>5/18/64</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Bernard Brack, MD.</u> | | 22b. ADDRESS <u>116 South main Windsor, Missouri</u> | |
| 22c. DATE SIGNED <u>5/19/64</u> | | 23d. LOCATION (City, town, or county) (State) <u>Windsor, Mo.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>May 20, 1964</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Oak</u> | |
| 24. FUNERAL DIRECTOR <u>Huston Funeral Home Windsor, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>May 25, 1964</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u> | | | |

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Glen E. Heck

Licensed Embalmer No. 4063
P. O. Address Green Ridge, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.